		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042101

Facility Name: Lawrence Community Healthcare Center

Address: 900 E. Corporation St. (Number) Bridgeport (City) 62417 (Zip Code)

County: Lawrence

Telephone Number: (618) 945-2091 **Fax #** (618) 945-9030

IDPA ID Number: 42101

Date of Initial License for Current Owners: 08/02/96

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[X] PROPRIETARY		[ ] GOVERNMENTAL	
	[ ] Charitable Corp.		[X] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code			[ ] Corporation		[ ] Other
			["Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact:
Name: John Knoblett **Telephone Number:** (618) 943-3344

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) William R. Gillis

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) John Knoblett, Member

(Firm Name & Address) Kemper CPA Group LLC, 1100 Lexington Ave., Lawrenceville, IL 62439

(Telephone) (618) 943-3344 Fax # (618) 943-2368

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,653	6,308	2,924	21,885	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,653	6,308	2,924	21,885	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.40%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/02/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/02/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 2,924

Medicare Intermediary Health Care Financing Administration

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 01/01/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	108,367	11,790	6,002	126,159	(239)	125,920		125,920			1
2	Food Purchase		101,621		101,621		101,621	(145)	101,476			2
3	Housekeeping	90,761	14,245		105,006		105,006		105,006			3
4	Laundry	36,601	13,126	37	49,764		49,764		49,764			4
5	Heat and Other Utilities			44,584	44,584		44,584		44,584			5
6	Maintenance	20,074	4,745	37,361	62,180	202	62,382		62,382			6
7	Other (specify):*											7
8	TOTAL General Services	255,803	145,527	87,984	489,314	(37)	489,277	(145)	489,132			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	579,419	25,467	12,294	617,180	(11,900)	605,280		605,280			10
10a	Therapy			86,829	86,829	(1,809)	85,020		85,020			10a
11	Activities	30,974	1,317	1,308	33,599		33,599		33,599			11
12	Social Services	20,888		1,308	22,196		22,196		22,196			12
13	Nurse Aide Training											13
14	Program Transportation			506	506	(457)	49		49			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	631,281	26,784	104,645	762,710	(14,166)	748,544		748,544			16
	C. General Administration											
17	Administrative	78,862		159,600	238,462	(44,511)	193,951		193,951			17
18	Directors Fees											18
19	Professional Services			13,808	13,808	644	14,452		14,452			19
20	Dues, Fees, Subscriptions & Promotions			8,565	8,565	107	8,672	(3,298)	5,374			20
21	Clerical & General Office Expenses	44,410		42,408	86,818	26,153	112,971	(1,772)	111,199			21
22	Employee Benefits & Payroll Taxes			141,609	141,609	5,579	147,188		147,188			22
23	Inservice Training & Education			1,476	1,476		1,476		1,476			23
24	Travel and Seminar			7,616	7,616	522	8,138		8,138			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,433	27,433	1,047	28,480		28,480			26
27	Other (specify):*											27
28	TOTAL General Administration	123,272		402,515	525,787	(10,459)	515,328	(5,070)	510,258			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,010,356	172,311	595,144	1,777,811	(24,662)	1,753,149	(5,215)	1,747,934			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lawrence Community Healthcare Center #0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			90,162	90,162		90,162		90,162			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			94,077	94,077		94,077	(5,375)	88,702			32
33	Real Estate Taxes			32,557	32,557		32,557		32,557			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,358	4,358	9,658	14,016		14,016			35
36	Other (specify):*											36
37	**TOTAL Ownership**			221,154	221,154	9,658	230,812	(5,375)	225,437			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			91,671	91,671	(9,530)	82,141		82,141			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):* **Cont/Exceptional Care**			681	681	24,534	25,215	(1,280)	23,935			43
44	**TOTAL Special Cost Centers**			146,704	146,704	15,004	161,708	(1,280)	160,428			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,010,356	172,311	963,002	2,145,669		2,145,669	(11,870)	2,133,799			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,375)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(145)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(269)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,280)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(353)	21		24
25	Fund Raising, Advertising and Promotional	(3,298)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,150)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,870)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (11,870)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Page 5A

Lawrence Community Healthcare Center

ID# 0042101

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lawrence Community Healthcare Center **#** 0042101 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(145)	0	0	0	0	0	0	0	0	0	0	(145)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(145)	0	0	0	0	0	0	0	0	0	0	(145)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,298)	0	0	0	0	0	0	0	0	0	0	(3,298)	20
21	Clerical & General Office Expenses	(1,772)	0	0	0	0	0	0	0	0	0	0	(1,772)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,070)	0	0	0	0	0	0	0	0	0	0	(5,070)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,215)	0	0	0	0	0	0	0	0	0	0	(5,215)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lawrence Community Healthcare Center **#** 0042101 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,375)	0	0	0	0	0	0	0	0	0	0	(5,375)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,375)	0	0	0	0	0	0	0	0	0	0	(5,375)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):* **Contributions**	(1,280)	0	0	0	0	0	0	0	0	0	0	(1,280)	43
44	**TOTAL Special Cost Centers**	(1,280)	0	0	0	0	0	0	0	0	0	0	(1,280)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,870)	0	0	0	0	0	0	0	0	0	0	(11,870)	45

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
William Rincker	100%	West Grove, Inc.	Lawrenceville, IL			
William Rincker	100%	Friendship Manor	St. Elmo, IL			
William Rincker	100%	Rincker Healthcare	Bridgeport, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-3	Management Fees	$ 159,600	Rincker Healthcare	100.00%	$ 159,600	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 159,600			$ 159,600	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	William Rincker	Administrator	Management	100.00	64,821	26		Wages	$ 33,718	17-1	1
2	Jane Rincker	Accountin Supr.	Bookkeeping		25,690	20		Wages	22,479	21-1	2
3	Rob Gillis	Ast. Administrator	Management		6,484	40		Wages	80,941	17-1	3
4	William Rincker	Administrator	Management	100.00	97,831			Mgmt fees	75,102	17-3	4
5	Jane Rincker	Accountin Supr.	Bookkeeping		7,200			Mgmt fees			5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 212,240		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Community Bank & Trust		X	Purchase	$8,357.26	08/02/96	$ 1,014,000	$ 908,897	08/02/16	8.0000	$ 73,901	1
2	Community Bank & Trust		X	Purchase	$1,885.98	09/08/97	200,035	175,462	09/08/12	8.0000	14,708	2
3	Community Bank & Trust		X	Purchase of Van	$658.24	11/23/99	32,080	25,969	11/23/04	8.0000	2,297	3
4	Amortization of Loan Costs		X								569	4
5												5
	Working Capital											
6	FNB-Bridgeport		X	Operating Capital	$3,000.00	08/22/96	100,000			8.0000	2,602	6
7												7
8												8
9	TOTAL Facility Related				$13,901.48		$ 1,346,115	$ 1,110,328			$ 94,077	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,346,115	$ 1,110,328			$ 94,077	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	12,266	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	22,411	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,145	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	22,411	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	32,556	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997	13,091	10
1998	12,417	11
1999	12,357	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	52,541	1996	$ 20,000	1
2					2
3	TOTALS	52,541		$ 20,000	3

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1996		$ 664,000	$ 16,600	40	$ 16,600	$	$ 74,700	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Siding			1997	5,300	133	40	133		464	9
10	Two 4 ton A/C units			1997	3,586	359	10	359		1,255	10
11	Fire Alarm System			1998	17,000	1,133	15	1,133		3,400	11
12	Telephone system w/ call lights			1998	17,300	1,730	10	1,730		4,181	12
13	Concrete pad			1998	734	49	15	49		114	13
14	Awing at back door			1998	890	59	15	59		138	14
15	Wallpaper/painting			1998	2,444	489	5	489		1,100	15
16	Asphalt parking lot			1998	13,374	1,337	10	1,337		3,678	16
17	Landscaping/trees/shrubs			1999	2,906	291	10	291		751	17
18	Parking lot			1999	1,029	103	10	103		129	18
19	Flooring/tiling			1999	12,600	1,260	10	1,260		2,415	19
20	Carpenter work			1999	3,645	243	15	243		445	20
21	Bathroom renovation			1999	3,570	238	15	238		417	21
22	Hot water system			1999	10,500	700	15	700		1,225	22
23	Hand rails			1999	3,520	235	15	235		411	23
24	Painting/wallpaper			1999	3,142	628	5	628		1,047	24
25	Alarm system			1999	5,297	353	15	353		559	25
26	Replacement Windows			2000	3,864	215	15	215		215	26
27	Water Heater			2000	4,350	326	10	326		326	27
28	Flooring/tiling			2000	3,200	213	10	213		213	28
29	Plumbing			2000	1,719	50	20	50		50	29
30	Fire Suppressin System			2000	1,849	31	25	31		31	30
31	Flooring/drywall			2000	2,600	108	10	108		108	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 788,419	$ 26,883		$ 26,883	$	$ 97,372	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 514,312	$ 54,158	$ 54,158	$	5 to 15	$ 227,579	37
38	Current Year Purchases	2,025	119	119		10	118	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 516,337	$ 54,277	$ 54,277	$		$ 227,697	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Transport patients	2000 Ford F-250 Super Van	1999	$ 36,009	$ 9,002	$ 9,002	$	4	$ 10,503	42
43										43
44										44
45										45
46	TOTALS			$ 36,009	$ 9,002	$ 9,002	$		$ 10,503	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,360,765	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 90,162	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 90,162	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 335,572	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Staff transportation	98 Toyota Camry Sedan	$ 363.16	$ 4,358	17
18					18
19					19
20					20
21	TOTAL		$ 363.16	$ 4,358	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs		$	571	$ 30,445	$	571	$ 30,445	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			107	6,307		107	6,307	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A-3	hrs			1,047	45,013	627	1,047	45,640	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program	43-5									12
13	Other (specify):										13
14	TOTAL				$	1,725	$ 81,765	$ 627	1,725	$ 82,392	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 143,778	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	216,551		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,381		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	82,780		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 445,490	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	664,000		14
15	Leasehold Improvements, at Historical Cost	124,419		15
16	Equipment, at Historical Cost	552,346		16
17	Accumulated Depreciation (book methods)	(335,572)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Prepaid Loan Costs	8,873		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,034,066	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,479,556	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,556	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	170		28
29	Short-Term Notes Payable	43,566		29
30	Accrued Salaries Payable	26,117		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,602		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,411		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Mgmt Fees	18,900		36
37	Accrued Insurance	21,813		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 195,135	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	201,431		39
40	Mortgage Payable	865,331		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,066,762	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,261,897	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 217,659	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,479,556	$	48

***(See instructions.)**

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 131,523	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 131,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	448,785	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(362,649)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 86,136	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 217,659	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,541,313	1
2	Discounts and Allowances for all Levels	(297,822)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,243,491	3
	B. Ancillary Revenue		
4	Day Care	110	4
5	Other Care for Outpatients		5
6	Therapy	148,498	6
7	Oxygen	37,553	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 186,161	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,049	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,102	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	109,980	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,681	19
20	Radiology and X-Ray	824	20
21	Other Medical Services	23,791	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 159,427	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,375	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,375	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,594,454	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	489,314	31
32	Health Care	762,710	32
33	General Administration	525,787	33
	B. Capital Expense		
34	Ownership	221,154	34
	C. Ancillary Expense		
35	Special Cost Centers	91,671	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37	Contributions	681	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,145,669	40
41	**Income before Income Taxes (line 30 minus line 40)****	448,785	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 448,785	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,136	2,156	$ 39,286	$ 18.22	1
2	Assistant Director of Nursing	2,056	2,076	32,720	15.76	2
3	Registered Nurses	7,918	8,267	123,302	14.91	3
4	Licensed Practical Nurses	7,403	7,883	98,270	12.47	4
5	Nurse Aides & Orderlies	35,762	38,202	276,144	7.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	488	488	3,506	7.18	9
10	Activity Assistants	4,194	4,295	29,013	6.76	10
11	Social Service Workers	2,024	2,210	20,888	9.45	11
12	Dietician					12
13	Food Service Supervisor	1,689	1,700	17,740	10.44	13
14	Head Cook	3,442	3,625	25,129	6.93	14
15	Cook Helpers/Assistants	7,421	7,546	52,715	6.99	15
16	Dishwashers	2,249	2,249	14,823	6.59	16
17	Maintenance Workers	1,976	2,051	20,075	9.79	17
18	Housekeepers	13,010	13,668	92,705	6.78	18
19	Laundry	3,709	4,243	31,346	7.39	19
20	Administrator	2,056	2,077	76,266	36.72	20
21	Assistant Administrator	1,490	1,647	24,235	14.71	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,968	3,188	22,887	7.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,307	1,370	9,306	6.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,298	108,941	$ 1,010,356 *	$ 9.27	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	137	$ 5,763	01-3	35
36	Medical Director	48	2,400	09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	600	39-3	39
40	Physical Therapy Consultant	48	1,838	10a-3	40
41	Occupational Therapy Consultant	6	371	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,434	11-3	44
45	Social Service Consultant	24	1,435	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	311	$ 13,841		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rob Gillis	Administrator		$ 78,862
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,862

B. Administrative - Other

Description	Amount
Management Fees	$ 159,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 159,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kemper CPA Group LLC	Accounting	$ 13,790
MES of Illinois	Other	18
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 13,808

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,663
Unemployment Compensation Insurance	19,706
FICA Taxes	79,104
Employee Health Insurance	25,715
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 147,188

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 263
Advertising: Employee Recruitment	3,612
Health Care Worker Background Check	456
(Indicate # of checks performed 38)	
Dues & Subscription	1,043
Advertising	3,298
Less: Public Relations Expense	( )
Non-allowable advertising	(3,298)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,374

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,138
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,138

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lawrence Community Healthcare Center # 0042101 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.